

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

12884

**1. PLACE OF DEATH**

County..... Registration District No. 797  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. 709 Glendale) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 3434

**2. FULL NAME**

Arbalds Gonzalez

(a) Residence No. 709 Glendale St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>2</u>		<u>27</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis

10. NAME OF FATHER Frank Gonzalez

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mexico

12. MAIDEN NAME OF MOTHER Amada Ybarra

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mexico

14. INFORMANT Arbalds Gonzalez  
 (Address) 709 Glendale

15. FILED 19 1929 Harold Stankler REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 19 29

17. I HEREBY CERTIFY That I attended deceased from March 12, 1929, to March 17, 1929 that I last saw him alive on March 17, 1929, and that death occurred, on the date stated above, at 3 P.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Bronchitis  
10 1/2 A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

CONTRIBUTORY (SECONDARY) not known  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRICTED at home  
 IF NEAR PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Signe  
 (Signed) H. T. Miller, M. D.  
2-19-1929 (Address) 730 Baden av

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Frederius DATE OF BURIAL Mar-19 19 29

20. UNDERTAKER Grant and Co ADDRESS 3710 N. Grand

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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CONTAINED  
HEREIN MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. **3434**  
 City..... (No. **709**) **Glendale** St. .... Word)

**2. FULL NAME**

**Orbaldo Goncalves**

(a) Residence. No..... St., ..... Ward.....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 20/28**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**2 27**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.**  
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address) **Max C. Staley**

15. FILED **1928** **Max C. Staley** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 17 1929**

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH..... (duration) yrs. mos. ds.

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED. DEATHS IN FINAL STAGES, SO THAT THEY MAY BE PROPERLY CLASSIFIED.

**SUPPLEMENTARY**

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